TRICARE Fundamentals Course

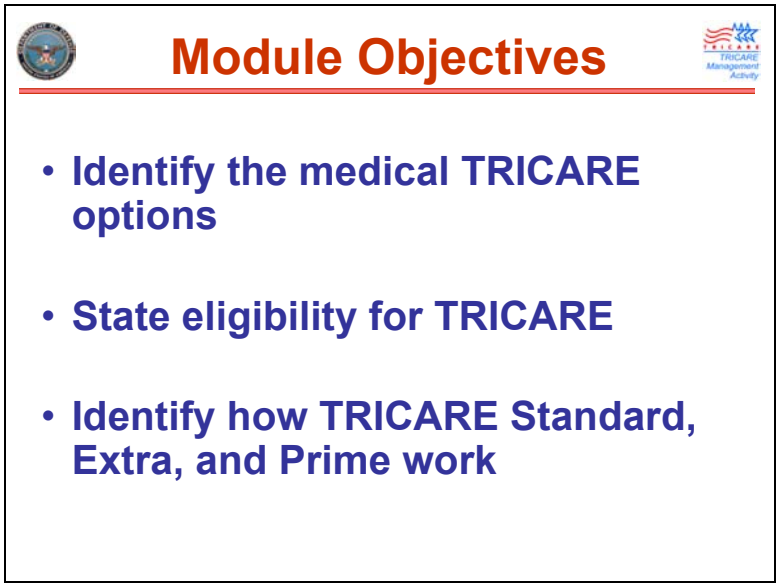
Module 4

Medical Benefits

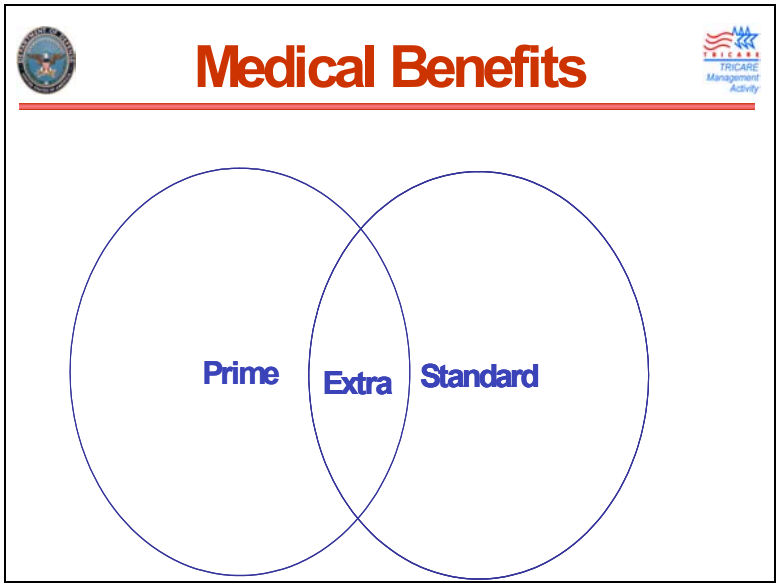
Participant Guide

References
10 U.S.C.
32 CFR §§ 199.14, 18, 20
National Defense Authorization Act (NDAA)
Defense Appropriations Act
TRICARE Policy Manual 6010.47-M

Module Objectives



Medical Benefits



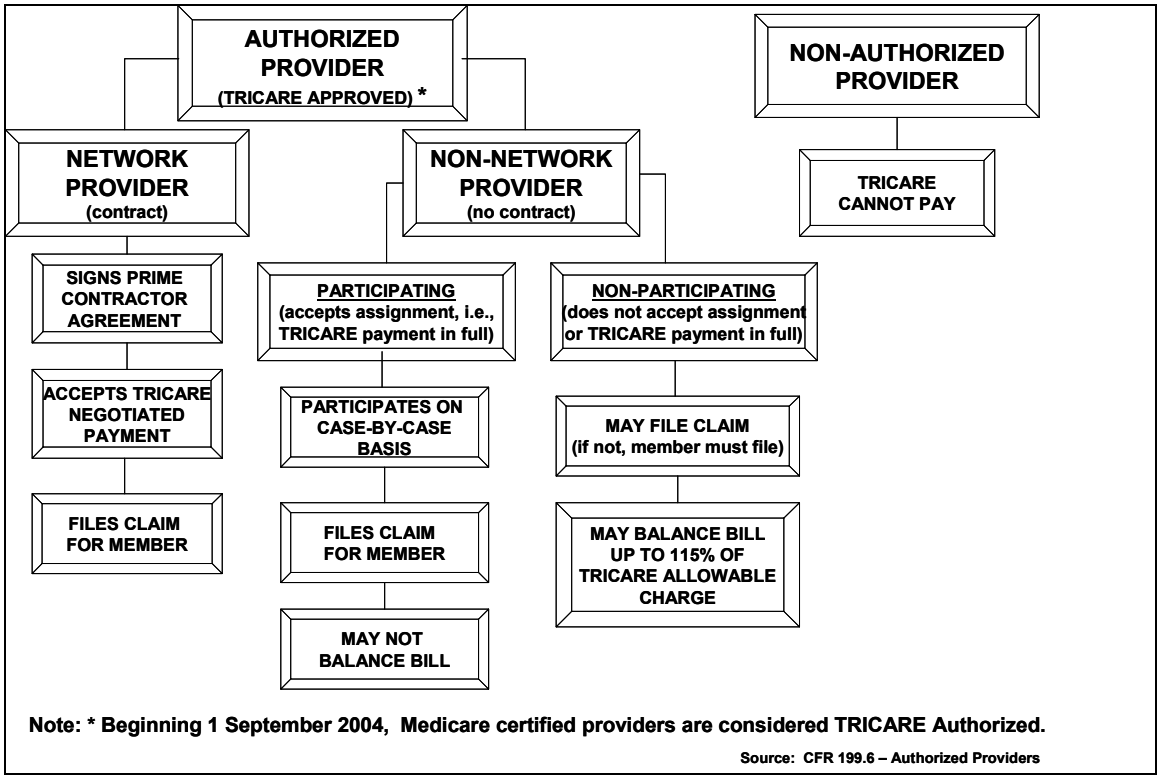
Program Definitions

- TRICARE Prime is a managed care option similar to a civilian health maintenance organization (HMO).
  - Advantages
    - Lowest out-of-pocket costs
    - Access to the military treatment facility (MTF)
    - Portability
- TRICARE Extra is a preferred provider option (PPO) in which beneficiaries choose a doctor, hospital, or other medical provider within the TRICARE provider network.
  - Advantages
    - Discounted cost shares
    - No claims to file
- TRICARE Standard is a fee-for-service option. The beneficiary can see an authorized TRICARE provider of their choice.
  - Advantages
    - Freedom to seek care from any TRICARE-authorized provider

Eligibility for TRICARE

- Active duty service members and their families
- Retirees and their families
- Certain unremarried former spouses
- Survivors of all uniformed services who are not eligible for Medicare
- Medal of Honor recipients and their families
  - *Note:* Medal of Honor recipients and their eligible family members must ensure correct registration in DEERS. Medal of Honor recipients maintain TRICARE eligibility including the TRICARE Dental Program whether they retired or separated from military service.

Kinds of Providers



The beneficiary is responsible for ensuring the provider delivering services is a TRICARE-authorized provider or a network provider, depending on the TRICARE option chosen. Recommend beneficiaries contact the office manager of the provider, the regional contractor's Web site or toll free line, or the local TRICARE Service Center (TSC) (where available).

Authorized Provider

An authorized provider is a doctor or other individual provider of care, hospital, or supplier licensed by the state, accredited by a national organization, or meets other standards of the medical community, and is certified by TRICARE to provide benefits under TRICARE.

Regional TRICARE contractors must verify (certify) a provider's authorized status before they can pay for services received from that provider. If the provider is not authorized, TRICARE cannot help pay the bill.

Note: Beginning September 1, 2004, all Medicare-certified providers who are recognized as a provider class under TRICARE are considered TRICARE-authorized providers.

Network Provider

A network provider is an individual or institution who serves TRICARE beneficiaries through a contractual agreement with the regional contractor and thus becomes a member of the TRICARE Prime network (or of any other preferred provider network or by any other contractual agreement with the contractor).

Non-network Provider

A non-network provider is one who has no contractual relationship with the prime contractor to provide care to TRICARE beneficiaries.

Participating Provider

A participating provider is a health care provider (institution, hospital, individual) who participates in TRICARE, or accepts assignments, meaning the provider, when submitting a claim form, agrees to accept the TRICARE allowable charge (including cost shares and deductibles, if any) as the full fee for care. Providers can participate on a case-by-case basis. The beneficiary or provider files the claim and the provider receives the reimbursement check from TRICARE. By law, hospitals that participate in Medicare must also participate in TRICARE for inpatient care. For outpatient care, hospitals and providers have the choice of whether to participate.

Non-participating Provider

A non-participating provider does not agree to participate or accept the TRICARE-determined allowable cost or charge as the total fee for services. A non-participating provider looks to the beneficiary for payment of billed charge(s), not TRICARE. In such cases, TRICARE pays the beneficiary directly who, in turn, is to pay the provider.

Non-authorized Provider

A provider of care who is not authorized under TRICARE might be someone like a chiropractor or an acupuncturist (classes of providers that are not recognized by TRICARE because the care they provide is outside the scope of TRICARE's benefit structure). Or it might be a physician who does not meet state licensing or training requirements, or who has not sought, or who has rejected, authorization to treat TRICARE-eligible patients.

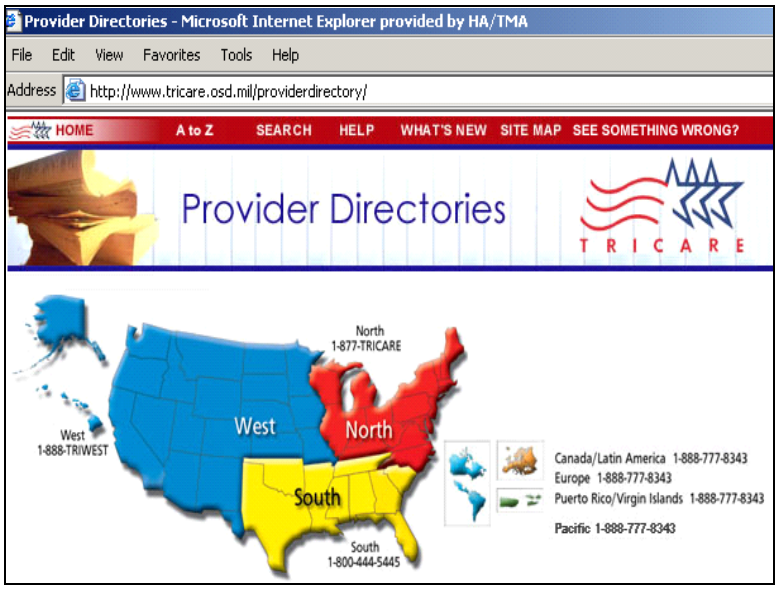
Before getting care, patients should ask providers of care if they are authorized providers under TRICARE. Providers themselves should volunteer this information before patients receive care if the patients don't ask on their own, since patients need to know ahead of time what their financial obligations might be. Ultimately, it's the patient's responsibility to know whether a provider is authorized under TRICARE, before getting care.

If patients ask about how their provider can become an authorized provider, refer them to this Web site: www.tricare.osd.mil/provider/provider_cert.cfm (*Note:* there is an underscore between provider and cert).

A search tool for TRICARE authorized providers is available at www.tricare.osd.mil/providerdirectory

The listings of doctors in the Provider Directories are always subject to change. The directories are updated periodically to reflect changes among network providers, participating providers, and authorized providers.

The provider's listing in a directory does not guarantee that the doctor's information is currently correct or that the doctor is currently accepting new patients. Advise beneficiaries to check with the physician's office, first, to verify that he/she is taking new patients.



Types of Charges in TRICARE

Allowable Charge

The allowable charge is the amount on which TRICARE figures the beneficiary's and government's cost share for covered services under TRICARE.

Balance Billing

Balance Billing occurs when a provider bills a beneficiary for remaining costs after being paid the TRICARE allowed amount. Federal law says the beneficiary is not legally responsible for amounts in excess of 15 percent above the TRICARE Allowable Charge.

Balance Billing Example

- Remember that a non-network provider can choose to "participate" or accept assignment on a case-by-case basis.
- A TRICARE Standard beneficiary sees a non-network provider for her cardiology appointment. The provider, who is a cardiologist, states that she will not participate for this service.
- The provider's rate for an outpatient cardiology appointment is $115.
  - TRICARE's allowable charge is $65.
  - The provider can now only balance bill the beneficiary for an additional 15% over the TRICARE allowable charge to recoup more money for the services she rendered.
    - Remember, 15% is the maximum allowable under federal law for a provider to charge a TRICARE beneficiary above the TRICARE allowable charge.

To further illustrate:
$115 = commercial rate for the cardiology appointment
$65 = TRICARE allowable charge

The non-participating provider bills the allowable extra 15 percent.
$65 = TRICARE allowable charge paid by claims processing unit by check
x .15 = Percentage allowed by federal law
$9.75 = The additional amount the provider can bill the beneficiary

Total amount due to the provider by the beneficiary
$65 + $9.75 = $74.75

The beneficiary will receive a $65 check from the claims processing unit (WPS or PGBA) as the claim cannot be paid directly to a non-participating provider. The beneficiary must pay the non-participating provider for services rendered. The additional $9.75 is what the beneficiary pay out-of-pocket for this visit.

Note: Beneficiaries should wait for their Explanation of Benefits (EOB) before paying additional money to a non-participating provider. Beneficiaries should ask claims processors how much they should pay the provider if the provider bills them directly, understanding that the amount should never be more than 15% of the TRICARE allowable amount.

Billed Charge

A billed charge is the total cost of care, without discounts or reduced fees from a provider.

Co-pay

Co-pay is the term used in Prime, that specifies fixed amounts of out-of-pocket expense(s) borne by the beneficiary for medical services or supplies can be delivered.

Cost Share

Cost Share is the out-of-pocket expense borne by the beneficiary for a TRICARE-covered medical service or supply based on the TRICARE allowable charge, associated with TRICARE Standard or Extra. This is expressed as a percentage: 25% or 20%, respectively of the TRICARE allowable charge.

Professional Fees

Professional fees are charges for medical professionals that the hospitals or third-party payers require to be separately identified on the billing form.

Health Care Options

- TRICARE Standard
- TRICARE Extra
- TRICARE Prime

TRICARE Standard

To get care with TRICARE Standard
- Freedom to choose any TRICARE-authorized provider
  - This is a fee-for-service option where you pay higher amounts for the freedom to choose from a larger network without having to get a referral or authorization for care

Eligibility

- Available for all TRICARE-eligible beneficiaries, except active duty service members, and dependent parents and parents-in-law

Enrollment

- No enrollment fees or enrollment forms

MTF Access

- Beneficiaries can still receive care from a military treatment facility on a space-available basis.

- Beneficiaries can self-refer for most specialty care.
  - Some outpatient procedures may require prior authorization – typically region specific
  - See the list of procedures and services requiring prior authorization on page 4-32

Costs

- Beneficiaries are responsible for annual deductibles and cost shares.
- Beneficiaries typically are required to file their own claims
- Government shares the cost for covered services with beneficiaries after deductibles are paid.
- For retired service members who have employer-sponsored health insurance/other health insurance, TRICARE Standard may be used as secondary coverage.

	Annual Deductible for an Individual	**Annual Deductible for a Family**
Active duty family member of E-1 to E-4	$50	$100
Active duty family member of E-5 and up; and all others	$150	$300

Enrollment Fees	**Cost Share after Deductibles**
$0–Enrollment not required Just show valid Uniformed Services ID card	20% cost share for active duty families 25% for retirees and retiree families, other than those that are Medicare-TRICARE eligible

The beneficiary must first pay the deductible per individual or family per fiscal year. The deductible applies to outpatient care only.

Catastrophic Cap

The catastrophic cap is the maximum amount per fiscal year a beneficiary pays for TRICARE-covered services or supplies.

	Active Duty Families Using TRICARE Standard	**TRICARE Standard Retirees/Retiree Family Members**
Catastrophic cap	$1,000 per family per fiscal year (Oct. 1–Sep. 30)	$3,000 per family per fiscal year (Oct. 1–Sep. 30)

Payments counted toward a TRICARE Standard beneficiary's catastrophic cap include the following:

- Deductibles
- Cost shares as well as prescription co-payments

Payments that do not count toward a beneficiary's catastrophic cap include the following:

- Payments for balance billing (excess of 15 percent above the TRICARE allowable charge)

Inpatient Costs

	Active Duty Families Using TRICARE Standard	**Retirees/Retiree Family Members under Age 65**
Civilian inpatient cost share	Greater of $25 or $13.90* per day	Lesser of $512* per day or 25% of billed charges plus 25% of allowed separately billed professional fees
Civilian inpatient mental health	$20 per day	Lesser of $169* per day or 25% of allowable fees plus 25% of allowed separately billed professional fees

*Fiscal Year (FY) 2005 rates

Cost Comparison Matrix for Active Duty Family Members (ADFM) and Retirees and Their Families

TRICARE Standard

TRICARE Standard	ADFM E1 – E4	ADFM E5 and up	Retirees/retiree family members under age 65
Enrollment Fee	0	0	0
Costs Shares	20%	20%	25%
Deductibles	$50 individual $100 family	$150 individual $300 family	$150 individual $300 family
Catastrophic Cap	$1,000 per family per fiscal year	$1,000 per family per fiscal year	$3,000 per family per fiscal year

Inpatient Costs

TRICARE Standard Inpatient Costs	Active duty families using TRICARE Standard	Retirees/retiree family members under age 65
Civilian inpatient cost share	Greater of $25 or $13.90* per day	Lesser of $512* per day or 25% of billed charges plus 25% of allowed separately billed professional fees
Civilian inpatient mental health	$20 per day	Lesser of $169* per day or 25% of allowable fees plus 25% of allowed separately billed professional fees

*FY 2005

TRICARE Extra

TRICARE Extra is the option where the TRICARE Standard beneficiary goes to a network provider and the cost share is 5 percent less than going to a non-network, authorized provider.

To get care with TRICARE Extra

1. Select civilian physicians and specialists from providers provided by the regional contractor's toll-free number or listed on the regional contractor's network provider directory.
2. Network providers can be used on a visit-by-visit basis. The provider will file the claim forms.

Eligibility

- Available for all TRICARE-eligible beneficiaries, except active duty service members and those enrolled in TRICARE Prime

Enrollment

- No enrollment fees or forms

MTF Access

- Beneficiaries can still receive care from a military treatment facility on a space-available basis.

Costs

- Care only by TRICARE network providers
- Claim paperwork submitted by providers
- No primary care managers (PCMs)
- Beneficiaries are responsible for annual deductibles and cost shares.
- Government shares the cost with beneficiaries after deductibles are paid.

	Annual Deductible for an Individual	**Annual Deductible for a Family**
Active duty family member of E-1 to E-4	$50	$100
Active duty family member of E-5 and up; and all others	$150	$300

Enrollment Fees	Cost Share after Deductibles
$0–Enrollment not required Just show Uniformed Services ID card	15% cost share and copay for active duty families 20% for retirees and retiree families other than those that are Medicare-TRICARE eligible

The beneficiary must first pay the deductible per individual or family per fiscal year. The deductibles apply to outpatient care only.

Catastrophic Cap

The catastrophic cap is the maximum amount per fiscal year a beneficiary pays for TRICARE-covered services or supplies.

	Active Duty Families Using TRICARE Extra	Retirees/Retiree Family Members under Age 65
Catastrophic cap	$1,000 per family per fiscal year (Oct. 1–Sep. 30)	$3,000 per family per fiscal year (Oct. 1–Sep. 30)

Payments counted toward a beneficiary's catastrophic cap include the following:
- Deductibles
- Cost shares as well as prescription co-payments

Payments that do not count toward a beneficiary's catastrophic cap include the following:
- Payments for balance billing (excess charges above the TRICARE allowable charge)

Note: As stated in contracts with the regional contractors, network providers cannot balance bill by federal law.

Inpatient Costs

	Active Duty Families Using TRICARE Extra	Retirees/Retiree Family Members under Age 65
Civilian inpatient cost share	Greater of $25 or $13.90* per day	Lesser of $250* per day or 25% of negotiated charges plus 20% of negotiated professional fees
Civilian inpatient mental health	$20 per day	20% of institutional and negotiated professional fees

*FY 2005 rates

Cost Comparison Matrix for Active Duty Families and Retirees

TRICARE Extra

TRICARE Extra	ADFM E1 – E4	ADFM E5 and up	Retirees/retiree family members under age 65
Enrollment Fee	0	0	0
Costs Shares	15%	15%	20%
Deductibles	$50 individual $100 family	$150 individual $300 family	$150 individual $300 family
Catastrophic Cap	$1,000 per family per fiscal year	$1,000 per family per fiscal year	$3,000 per family per fiscal year

Inpatient Costs

TRICARE Extra Inpatient Costs	Active duty families using TRICARE Extra	Retirees/retiree family members under age 65
Civilian inpatient cost share	Greater of $25 or $13.90* per day	Lesser of $250* per day or 25% of billed charges plus 20% of allowed separately billed professional fees
Civilian inpatient mental health	$20 per day	20% of institutional and negotiated professional fees

*FY 2005

Sequence of Paying Costs for TRICARE Standard and TRICARE Extra

Sequence of Paying Costs for TRICARE Standard

	E-1 to E-4 Family Members		E-5 and above Family Members		Retirees under 65	
	Individual	Family	Individual	Family	Individual	Family
1 – Deductible up to:	$50	$100	$150	$300	$150	$300
2 – Cost Share	20%	20%	20%	20%	25%	25%
3 – Nothing after Catastrophic Cap is reached per Fiscal Year	Cat Cap for family is $1000		Cat Cap for family is $1000		Cat Cap for family is $3000	

Sequence of Paying Costs for TRICARE Extra

	E-1 to E-4 Family Members		E-5 and above Family Members		Retirees under 65	
	Individual	Family	Individual	Family	Individual	Family
1 – Deductible up to:	$50	$100	$150	$300	$150	$300
2 – Cost Share	15%	15%	15%	15%	20%	20%
3 – Nothing after Catastrophic Cap is reached per Fiscal Year	Cat Cap for family is $1000		Cat Cap for family is $1000		Cat Cap for family is $3000	

TRICARE Standard Sequence of Payments

Mrs. Green, an Active Duty Family Member, and her three children moved to live with Grandma in a non-network location while her husband/their father, an E-4, is deployed to Iraq. Mrs. Green had a routine check-up with a family physician, who had chosen to be a participating provider, several weeks ago. This was the first outpatient visit of the fiscal year for the Green family. Mrs. Green's first visit cost $50.00. She had one follow-up visit that also cost $40.00. In between her two doctor visits, her three children were seen by the same provider for ear infections. Each of their visits cost $40.00.

	$ Amount	How much was applied toward the deductible?	How much cost share did Mrs. Green pay (Cost share % and $ amounts)?
How much did Mrs. Green pay for her first doctor's visit?			
How much did Mrs. Green pay for her three children's doctor's visit?			
How much did Mrs. Green pay for her follow-up doctor's visit?			

TRICARE Extra Sequence of Payments

Mrs. Green, an Active Duty Family Member, and her three children moved to live with Grandma within 10 miles from a military installation while her husband/their father, an E-5, is deployed to Iraq. They chose not to enroll in TRICARE Prime. Mrs. Green had a routine check-up with a family physician, who is part of the TRICARE Network, several weeks ago. This was the first outpatient visit of the fiscal year for the Green family. Mrs. Green's first visit cost $100.00. She had one follow-up visit that cost $75.00. In between her two doctor visits, her three children were seen by the same provider for ear infections. Each of their visits cost $75.00.

	$ Amount	How much was applied toward the deductible?	How much cost share did Mrs. Green pay (Cost share % and $ amounts)?
How much did Mrs. Green pay for her first doctor's visit?			
How much did Mrs. Green pay for her three children's doctor's visit?			
How much did Mrs. Green pay for her follow-up doctor's visit?			

TRICARE Prime

TRICARE Prime is a managed care option similar to a civilian health maintenance organization.

Eligibility

- Active duty service members
- Active duty family members
- Retirees, retiree family members, and eligible survivors who are not Medicare eligible
- Certain Reserve component members and their family members

Note: All eligible beneficiaries must be properly registered in the Defense Enrollment Eligibility Reporting System (DEERS) and they must live in a service area where TRICARE Prime is offered.

TRICARE Prime for Active Duty Service Members

- Required to use TRICARE Prime
  - Active Duty Service Members
  - National Guard
  - Reservists
  - ROTC Students – active duty when performing military-related functions
  - Service Academy Cadets – active duty when ID cards are issued on the first day at Service Academy

Enrollment

- Requires enrollment to participate
- Active duty service members are required to enroll:
  - Active duty service members must complete an enrollment application
  - This is the only TRICARE option for which they are eligible.
  - Active duty service members receive priority access to care at all MTFs.
  - Open enrollment year round
- For TRICARE eligible beneficiaries, other than active duty service members:
- 20th of each month is the cut-off date for all new enrollments for the following month
- After the 20th, enrollment is effective the first of the second month
  - Enrollment is for a 12-month period and enrollment fee payment is pro-rated to coincide with fiscal year quarters
  - Reenrollment is automatic. Letter sent to sponsor 30 days before anniversary date of enrollment notifying of annual automatic reenrollment unless sponsor wants to disenroll.

Enrollment Process

- To enroll in TRICARE Prime, eligible beneficiaries must be enrolled in DEERS and must complete an enrollment form (DD Form 2876) by visiting the local TSC or downloading the enrollment form from the TRICARE Web site (www.tricare.osd.mil/enrollment/). Beneficiaries should return the completed form along with the enrollment fee, if applicable by visiting the closest TSC or mailing it to their regional contractor.
- Retirees and their family, Medal of Honor recipients and their family, former spouses, and others (not on active duty) so designated by DoD who are eligible beneficiaries pay an annual enrollment fee ($230.00 per individual/$460.00 per family) that must accompany the completed enrollment form.
- The fee is payable by: personal check, major credit card, travelers' check, money order, cashiers check, electronic funds transfer, or allotment. Payments can be made annually, quarterly ($57.50 individual/$115.00 family), or monthly ($19.17 individual/$38.34 family).

Note: Enrollment fees are waived for beneficiaries who are eligible for Medicare on the basis of disability or end-stage renal disease and maintain enrollment in Medicare Part B.

MTF Access

- TRICARE Prime enrollees receive most of their care from military providers or from civilian providers who belong to the TRICARE civilian network.
- TRICARE Prime is portable when you have a permanent change of station (PCS) or go on temporary duty/temporary additional duty (TDY/TAD) where Prime is offered.
- Primary Care Manager (PCM) assignment

Role of the PCM

- Provides and coordinates care:
  - Provides all non-emergency health care including urgent care
  - Submits referrals to coordinate authorizations for specialty care
- Maintains health records
  - Active duty service members can get copies of their health records from civilian PCMs at no cost
  - All other Prime beneficiaries can get copies of their health records from civilian PCMs at a nominal cost

Costs

- No claims to file
- There is no cost to the Active duty service member

Active duty members and their families

Enrollment Fees	Annual Deductibles	Copayments
$0	$0	$0

Active duty members receiving military inpatient care, pay only subsistence charges to military facility, if they are receiving subsistence pay. Otherwise they have no inpatient costs to pay.

Enrollment fees for retirees and others, not active duty

	Monthly	Quarterly	Yearly
Single	$19.17	$57.50	$230.00
Family	$38.34	$115.00	$460.00

- The fees may be paid annually, quarterly, or monthly
- Fees can be paid by personal check, major credit card, debit card, travelers' check, money order, cashiers' check, electronic funds transfer, or allotment
- For electronic funds transfers, beneficiaries need to make arrangement through their financial institution (bank, credit union, etc.)
  - The beneficiary should check the regional contractor's Web site, call the regional contractor, or call their financial institution monthly or close to the end of the first quarter to see if the funds transfer is in effect.
  - Making this call will ensure continuity of care is not interrupted due to non-payment of monthly fees.
- For allotments from their Service retirement pay, beneficiaries need to make arrangements for monthly deductions from their pay agency: Defense Financial Accounting System (DFAS), Coast Guard, or Public Health Service.
- The enrollment form should accompany the first quarter payment by a personal check, credit/debit card information, travelers' check, money order, or cashiers check.

Note: Dual-eligible, is a beneficiary who has been designated Medicare eligible and does not pay the annual enrollment fee, so long as enrollment in Medicare Part B is maintained. A dual-eligible beneficiary must be registered in DEERS as having dual-eligibility with both TRICARE and Medicare.

Co-pays for retirees and others, not active duty

Annual Deductibles	Copayments
$0	$12 outpatient $30 emergency care $25 mental health $17 mental health group session

Catastrophic Cap

The catastrophic cap is the maximum amount per enrollment year a beneficiary pays for TRICARE-covered services and supplies. This is less of an issue for active duty families using TRICARE Prime since they have few, if any out-of-pocket expenses. It is more of a concern for retirees and their family members.

	Active Duty Families Using TRICARE Prime	Retiree Families Using TRICARE Prime
Catastrophic cap	$1,000 per family per fiscal year	$3,000 per family per fiscal or enrollment year

Payments counted toward a beneficiary's catastrophic cap include the following:
- Enrollment fees
- Deductibles
- Co-payments

Payments that do not count toward a beneficiary's catastrophic cap include the following:
- Payments for balance billing
- Point of Service charges

Note: As stated in contracts with regional contractors, network providers cannot balance bill by federal law.

Inpatient Costs

Active duty family members do not have to pay inpatient costs.

For retirees and their family members

Civilian inpatient cost share	MTF: $13.90, Civilian: $11/day ($25 minimum charge per admission)
Civilian inpatient mental health	$40 per day

TRICARE Prime

TRICARE Prime	ADFM E1 – E4	ADFM E5 and up	Retirees/retiree family members under age 65
Enrollment Fee	0	0	$230 individual $460 family
Costs Shares	0	0	Co-pays $12 outpatient $30 emergency $25 mental health $17 mental health group session
Deductibles	0	0	0
Catastrophic Cap	$1,000 per family per fiscal year	$1,000 per family per fiscal year	$3,000 per family per fiscal or enrollment year

Inpatient Costs

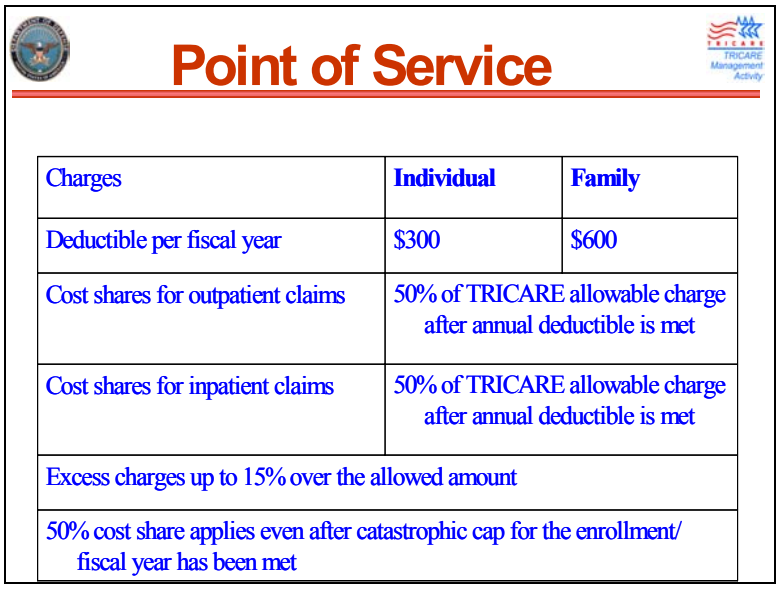
TRICARE Prime Inpatient Costs	Active duty families using TRICARE Prime	Retirees/retiree family members under age 65
Civilian inpatient cost share	0	MTF: $13.90 Civilian: $11 per day ($25 minimum charge per admission)
Civilian inpatient mental health	0	$40 per day

Preventive Care Services:
- Eye exams
- Immunizations
- Hearing tests
- Mammograms
- Pap tests
- Prostate exams

Point of Service Option (POS)

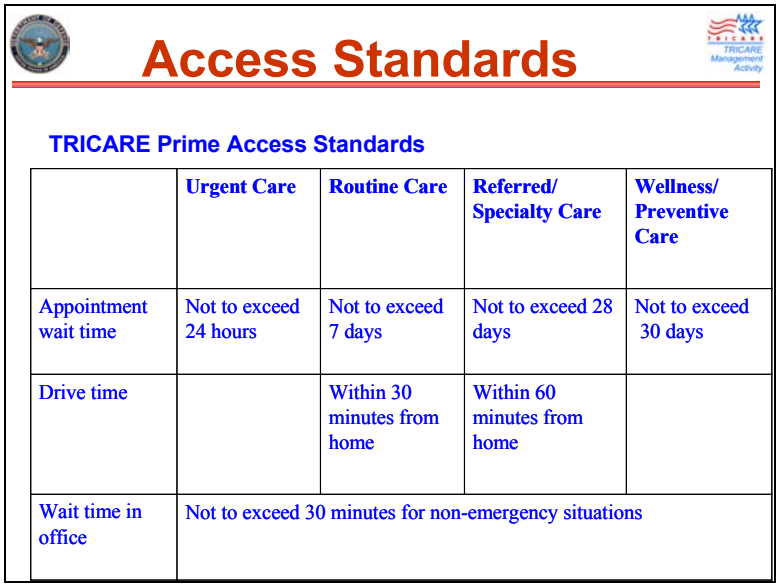
- Provides increased flexibility to self-refer to specialty providers without authorization but at a significantly increased cost to the TRICARE Prime member.
- Enrollees can receive non-emergent specialty or inpatient health care services from any TRICARE-authorized civilian provider, in or out of network, without requesting a referral from the PCM.
- All TRICARE Standard coverage rules apply.

POS Charges	**Individual**	**Family**
Deductible per fiscal year	$300	$600
Cost shares for outpatient claims	50% of TRICARE-allowable charge after annual deductible is met	
Cost shares for inpatient claims	50% of TRICARE-allowable charge after annual deductible is met	
Excess charges up to 15% over the allowed amount		
50% cost share applies even after catastrophic cap for the enrollment/fiscal year has been met		



Access Standards

This is the time it should take for a TRICARE Prime beneficiary to be seen by a provider based on the type of care being sought.



	Urgent Care	Routine Care	Referred/ Specialty Care	Wellness/ Preventive Care
Appointment wait time	Not to exceed 24 hours	Not to exceed 7 days	Not to exceed 28 days	Not to exceed 30 days
Drive time		Within 30 minutes from home	Within 60 minutes from home	
Wait time in office	Not to exceed 30 minutes for non-emergency situations			

Emergency Services—For medical, maternity, or psychiatric emergencies that would lead a "prudent layperson," (someone with average knowledge of health and medicine), to believe that a serious medical condition existed or the absence of medical attention would result in a threat to his/her life, limb, or sight and requires immediate medical treatment or which manifest painful symptomatology requiring immediate palliative effort to relieve suffering. This includes situations where a beneficiary presents with severe pain.

Urgent care—Generally defined as non-emergency illness or injury for which you need medically necessary treatment. But, it will not result in disability or death if it is not treated immediately. This kind of illness or injury does require professional attention, and should be treated within 24 hours to avoid further complications. The PCM should be the primary source of all urgent and routine care. POS charges may apply if urgent care is required when traveling and no referral is sought from the PCM or authorization provided by the regional contractor.

Routine Care—General outpatient (sick call) visits to a doctor, including laboratory tests and X- rays as well as preventive diagnosis health care under Prime, but must be provided by PCM.

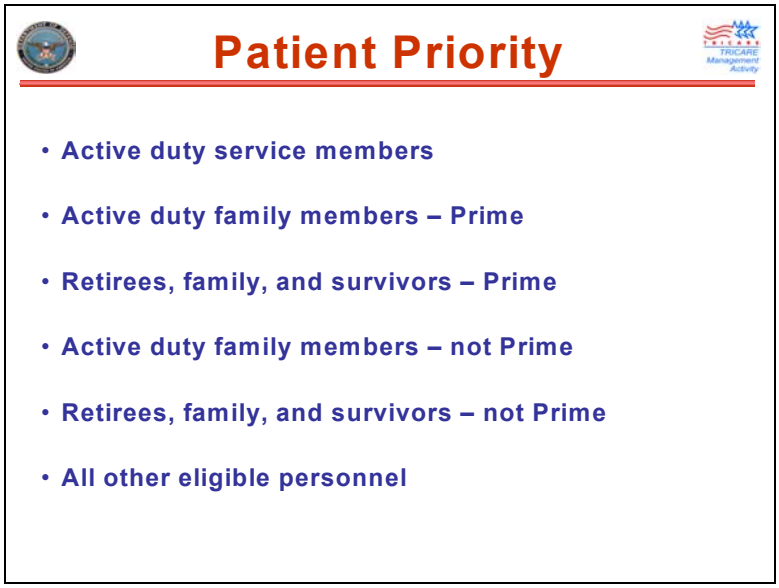
Specialty Care—Generally defined as care the PCM is not able to provide.

Wellness/Preventive Care—Routine care with PCM based on history such as physicals.

Referral for Specialty Care

- When beneficiaries are referred for specialty care by their PCM, the PCM must write a referral or consult. It is the beneficiary's responsibility to make sure that the care is authorized by the regional contractor before they schedule the specialty appointment. Getting the referral authorized can happen in at least two ways:
  - Beneficiaries take the written referral/consult from the PCM and take it to the local TRICARE Service Center. The beneficiary can then verify authorization by calling the regional contractor's toll-free number at a specific later date and speak to a Health Care Finder (HCF).
    - The beneficiary may make the appointment to meet his or her needs; authorization is only good for 30 days.
  - The PCM sends the consult via fax or electronically to the regional contractor, and, after waiting at least 48 hours so the consult can clear through the authorization process, the beneficiary calls the regional contractor's toll-free number to validate the authorization prior to making an appointment.
    - Regional contractors will send letters to beneficiaries with the name(s) of network providers and the referral authorization.
    - The beneficiary contacts the providers listed in the letter to make an appointment.
- The beneficiary should find out from his/her provider what copies of information pertaining to the referral (x-rays, labs, etc.) they should take with them. Beneficiaries should also take the address and phone number of their PCM with them to their referral/specialty appointment.
- TRICARE Prime beneficiaries should be reminded that if they do not make sure there is a referral and authorization, they will end up paying out-of-pocket and the 50% POS option will be applied.
- As a BCAC, you need to find out what measures the local MTF has put in place to manage outpatient medical records and privacy standards by contacting:
  - Local patient administration division,
  - MTF privacy officer, or
  - MTF outpatient medical records office.

Patient Priority



The priority for care in an MTF is as follows:

1. Active duty service members
2. Active duty family members enrolled in TRICARE Prime (survivors of military sponsors who died on active duty who are enrolled in TRICARE Prime are included for the first 3 years after the sponsor's death)
3. Retirees, their family members, and survivors enrolled in TRICARE Prime
4. Active duty family members not enrolled in TRICARE Prime (survivors of military sponsors who died on active duty who are not enrolled in TRICARE Prime are included)
5. Retirees, their family members, and survivors not enrolled in TRICARE Prime
6. All other eligible personnel

TRICARE Portability

The TRICARE Prime benefit is portable as long as the beneficiary lives where Prime is offered. The TRICARE Standard benefit is universal, meaning the benefit is the same no matter where the beneficiary lives or travels.

If TRICARE Prime and Moving Within the Same Region

- Make sure Prime is available in the new location.
- Update address in DEERS.
- Notify regional contractor of address change.
- Submit change PCM form.
- If TRICARE Prime is not available where a beneficiary will be living, the beneficiary should disenroll from Prime once reaching a new location. Fill out a Disenrollment Form and send it to the regional contractor – coverage will then change to TRICARE Standard (if they are still eligible).

If Prime and Moving to a Different Region

- Make sure Prime is offered in the new location
- Don't disenroll before moving. Beneficiaries transfer their enrollment after arriving at a new location by filling out a new Enrollment Form.
- If Prime is not available where a beneficiary will be living, the beneficiary should disenroll from Prime once reaching a new location. Fill out a Disenrollment Form and send it to the region previously enrolled in – the beneficiary's health coverage will then change to TRICARE Standard (if they are still eligible).
- Enrollment transfer is effective on the date the new regional contractor processes the enrollment application.
- Both enrollment transfer and PCM selection can be done by visiting a TSC.
- Beneficiaries will receive new enrollment cards and local health care information if moving to a new region.
- The enrollment is retained.
- Future enrollment fees will be paid to the new regional contractor so electronic funds transfers may need to be reviewed.
- Active duty families may have unlimited number of enrollment transfers.

From TRICARE Prime to Non-Prime

- Covered in TRICARE Prime while in transit
- If anticipating a move to an area without TRICARE Prime, pay enrollment fees quarterly or monthly.
- Upon arrival at non-TRICARE Prime site, beneficiary should call the regional contractor or visit the closest TSC regarding disenrollment.
- Beneficiary may sign a waiver to TRICARE Prime access standard to remain enrolled even when moving to a location that is out of the Prime service area.
  - Beneficiary will travel a longer distance to see a TRICARE Prime provider and must still abide by all the rules in TRICARE Prime.

From Non-Prime to TRICARE Prime

- Make sure TRICARE Prime is available in the new location.
- Update address information in DEERS.
- Complete an enrollment form (DD Form 2876) by visiting the local TSC or downloading the enrollment form from the TRICARE Web site www.tricare.osd.mil/enrollment.
- Return the completed form along with the enrollment fee, if applicable, by visiting the closest TSC or mailing it to their regional contractor.
  - Retirees and their family members, Medal of Honor recipients and their family members, former spouses, and others (not on active duty) so designated by DoD who are eligible beneficiaries must ensure their enrollment form is accompanied by the first quarter payment by a personal check.
- The 20th of the month rule applies for active duty family members and retirees under 65 and their eligible family members.

Retirees and Their Eligible Family Members

- Retirees and their eligible family members who move from one region to another and then back to original region of enrollment are unofficially referred to as "snowbirds." TRICARE accommodates snowbirds but limits region-to-region Prime moves to two per enrollment year.
- Number of moves within a region is unlimited.
- Can transfer Prime enrollment to another region without paying additional enrollment fees.
- If anticipating a move to an area without TRICARE Prime, pay enrollment fees quarterly or monthly.
- If beneficiary will turn 65 during enrollment year, also recommend paying quarterly or monthly.

Traveling with TRICARE

- For emergency care, go to the nearest hospital emergency room based on the Prudent Lay Person Rule (someone with average knowledge of health and medicine). If enrolled in Prime, beneficiary is required to notify the PCM or regional contractor within 48 hours of being admitted to an inpatient facility. It is recommended that a copy of the treatment record be forwarded to the PCM. Immediate notification to the PCM and/or HCF is important in the TRICARE Overseas Program only.
- For non-emergency care including urgent care, beneficiaries should call for authorization from the PCM or HCF at the regional contractor.

TRICARE Prime Travel Benefits

The Prime travel entitlement applies in the following situation. The beneficiary:
- The beneficiary is a non-Active Duty TRICARE Prime enrollee AND
- The beneficiary's Primary Care Manager decides the beneficiary needs non-emergent, medically necessary, specialty care AND
- The beneficiary will have to travel more than 100 miles from the PCM's location/office to get that specialty care
  - The beneficiary will be paid for out of pocket "reasonable travel expenses" incurred when traveling to the specialist.

The entitlement covers medically necessary outpatient or inpatient specialty care. Non-covered and elective specialty care visits do not qualify apply (e.g., elective cosmetic surgery). The Prime travel entitlement does not apply to emergency care because a PCM referral is not required in the case of an emergency.

For more information on this benefit, go to the TRICARE Prime Travel and Non-Medical Attendant Entitlements Web site at: www.tricare.osd.mil/primetravel/default.cfm.

Split Enrollment Between Different TRICARE Regions

- Occurs when eligible family members live in a region different from their sponsor
- Pay one enrollment fee to whichever regional contractor is chosen to be the home region by the beneficiaries in the region(s) where they live.
- Contact the regional contractor or Beneficiary Counseling and Assistance Coordinator (BCAC) for more information.

Maternity Care

- Effective December 28, 2003, pregnant women family members who are under TRICARE have more choices for their prenatal care, labor, and delivery.
  - Women family members can choose to stay enrolled in Prime and receive their care through their PCM who is an OB/GYN or be referred by their family practice PCM to an OB/GYN specialist for care in the MTF.
  - The other option available for pregnant women family members is to participate in TRICARE Standard and see a civilian OB/GYN provider or midwife, and use civilian facilities without having to request a non-availability statement (NAS) from their local MTF.

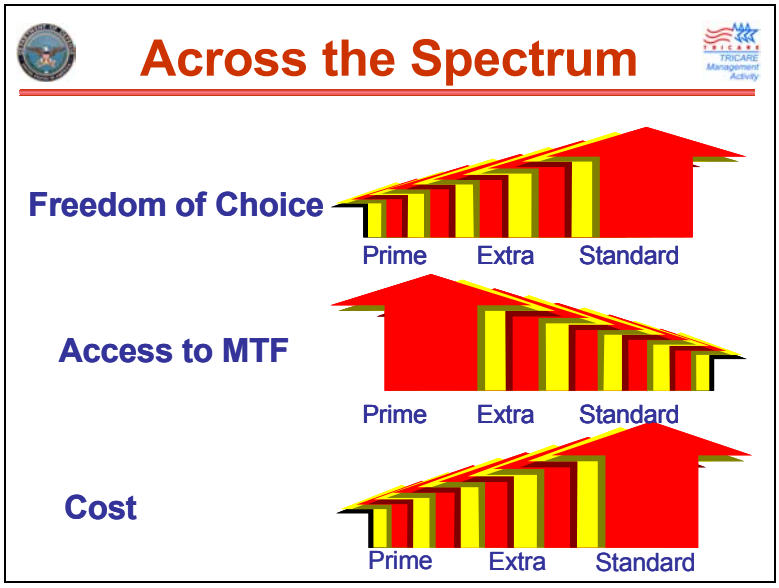
Note: Women who voluntarily disenroll from TRICARE Prime for maternity care are locked out for 12 months. The exception is women with sponsors rank of E-4 and below.

- For more information on maternity care, refer to the TMA Web site at www.tricare.osd.mil/familycare/beneficiary/default.cfm
- Active duty women who are pregnant do not have the option of participating in TRICARE Standard.
  - DoD policy dictates they must enroll in TRICARE Prime and receive OB/GYN care from an MTF.
  - They can only be seen by civilian providers and in civilian facilities if directed due to the lack of an MTF in the local area.
- Active duty pregnant women who voluntarily choose to administratively separate from the military should ensure they receive pre-separation counseling from their MTF in regards to available MTF resources to support their pregnancy and delivery upon separation.
  - They do not have TRICARE benefits upon voluntary separation.
  - They may enroll in the premium-based Continued Health Care Benefits Program (CHCBP) for 18 months.
  - A Certificate of Creditable Coverage will be issued by DEERS to provide to any future commercial carrier.

Care at Department of Veterans Affairs (VA) Health Care Facilities

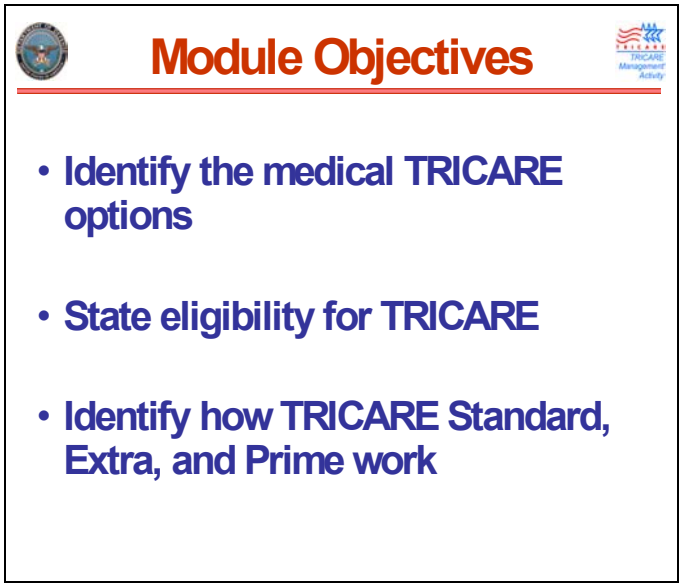
- Many VA health care facilities participate as regional TRICARE networks.
- VA facilities may or may not provide primary care for active duty service members and their family members.
- Many VA facilities provide specialty care.
- Contact the regional contractor to find out if a participating VA facility can provide care.

Choosing a Health Care Option



- If freedom of choice is most important to beneficiaries, TRICARE Standard will likely be their preferred choice for health care.
- If priority access to the Military Treatment Facility is most important to beneficiaries, TRICARE Prime will give them the best priority access.
- If cost savings is most important to beneficiaries, TRICARE Prime is their best health care choice with TRICARE Extra as the next best choice.
- Out of pocket costs for beneficiaries mirror the freedom of choice factor.
  - Complete freedom of choice is the most costly.
  - Whereas, the limited freedom of choice helps beneficiaries achieve the biggest savings.
- Because choosing a health plan can be confusing and complex, a TRICARE Health Comparison Site was created.
- Visit www.tricare.osd.mil/tricarecomparisions/admin/index.cfm
  - This site compares TRICARE Standard, TRICARE Extra, and TRICARE Prime to other health insurance.

Summary



Program Matrix Homework Instructions

- Using your TRICARE Fundamentals Course Participant Guide and class notes, write the appropriate answer in each of the squares on the Program Matrix.
- Answers:
  - Can be either Yes or No.
  - May be "not applicable" or "does not apply"—fill in the square with NA.
  - May require dollar amounts only.
  - Some Yes answers may also require the name of a program or who is responsible.
  - In the Claims section, the answer should be the reason why a claim had to be filed or NA.
- Suggestion: Do the homework with the help of a study group.

Present the Topic, Procedures and/or Services Requiring Prior Authorization

TRO-North: Health Net Procedures and/or Services Requiring Prior Authorization

TRICARE Prime (includes TRICARE Prime Remote and TRICARE Prime Remote for Active Duty Family Members)

Inpatient Procedures
- All elective acute inpatient admissions
- All non-emergent admissions for substance abuse or behavioral health
- All emergency admissions require notification to Health Net within 24 hours of admission or by the next business day

Outpatient Procedures and Equipment
- Adjunctive dental care
- Chelation therapy
- Durable medical equipment (DME), orthotics, and prosthetics
  - Purchase, when ≥ $500 billed charges
  - Rental, when purchase price is ≤ $500 billed charges
- Hearing aid services (bone anchored hearing aids)
- Home health services
- Hospice
- Non-network providers (services on the prior authorization list for TRICARE Prime beneficiaries performed by non-network providers after the initial approved referral)
- New and evolving technology or experimental services
- Nutritional therapy
- Obstetrics and Gynecology (radiology, global and high-risk maternity, and sub-total hysterectomy)
- Oral surgery
- Program for Persons with Disabilities (PFPWD)
- Psychiatric (psychotherapy, psychoanalysis, electroconvulsive therapy ([ECT])
- Radiology (magnetic resonance imaging [MRI], magnetic resonance angiography [MRA], positron emission tomography [PET], and single-photon emission computed tomography [SPECT]
- Reconstructive, plastic, or cosmetic surgery
- Rehabilitation
  - Cardiac and pulmonary rehabilitation
  - Occupational, physical, and speech therapy
- Surgery for morbid obesity
- Transplants—all solid organ and stem cell transplants (excludes corneal)

TRICARE Extra and Standard

Inpatient Procedures
- All non-emergent admissions for substance abuse or behavioral health
- All admissions for adjunctive dental care, transplants, PFPWD

Outpatient Procedures and Equipment
- Adjunctive dental care
- Home health services
- Hospice
- Psychiatric (psychotherapy, psychoanalysis, electroconvulsive therapy ([ECT])
- Transplants—all solid organ and stem cell transplants (excludes corneal)

TRO-South: Humana Procedures and/or Services Requiring Prior Authorization

Procedures/Services
- Adjunctive dental services
- Admission or transfer to skilled nursing facilities (SNF), rehab hospitals, and long term acute care (LTAC) facilities
- Blepharoplasty
- Home health services
- Hospice care
- Hysterectomy
- Inpatient non-emergency mental health admissions
- Outpatient mental health visits more frequently than one per week
- Program for Persons with Disabilities (PFPWD)
- Reduction mammoplasty
- Septoplasty
- Speech therapy
- Transplants for solid organ and stem cell
- Termination of pregnancy
- Uvulopalatopharyngoplasty (UPPP)

Humana Military also requires prior authorization when admission to acute care hospital is required.

Durable Medical Equipment Items Requiring Prior Authorization for Rental or Purchase
- Electric hospital bed
- Continuous positive airway pressure (CPAP) machine
- Apnea monitor
- Patient lifts
- Pneumatic compressor
- Bone stimulator
- Continuous passive motion (CPM) machine
- Power vehicle or wheelchair
- Certain orthotics
- Certain prosthetics
- Any miscellaneous code if line item rental or purchase price is greater than $500

Inpatient Hospital Stays
- Admissions or transfers to Skilled Nursing Facilities, rehabilitation facilities, or long term acute care facilities
- Notification of admission within 24 hours of admission to acute care facility
- Discharge notification
- Concurrent review upon request by Humana Military

Behavioral Health Care Services
- Inpatient behavioral health admissions
- Psychoanalysis
- Psychological testing
- Neuropsychological testing
- Electroconvulsive therapy (ECT)
- Outpatient crisis intervention

TRO-West: TriWest Procedures and/or Services Requiring Prior Authorization

Procedures
- Any service performed by a dentist (Adjunctive Dental care and TMJ, oral/maxillofacial surgery)
- Tova testing
- Hospice
- Program for Persons with Disabilities
- Magnetic resonance angiography (MRA)
- Positron emission tomography (PET)/single-photon emission computed tomography (SPECT)/bone scan
- Head and spinal, head and brain (MRI) magnetic resonance imaging

- Therapy (Occupational, Physical, Speech [OT/PT/ST])
  - TRICARE Prime: Preauthorization required for first 20 visits. Physician review required after initial 20 visits
  - TRICARE Standard and TRICARE Extra: Preauthorization required beyond the first 20 visits
- Durable medical equipment (DME) allowable charges for purchase price exceeding $1000. DME cumulative rental charge that exceed the purchase price of $1000
- Liquid oxygen
- Insulin, External, and Parenteral Pumps
- Home health care (Professional Component)

Outpatient behavioral health
- Psychoanalysis
- Electroconvulsive therapy (ECT)
- Individual psychophysiological therapy
- Medical hypnotherapy
- Interpretation of Explanation of Results (collateral visits)
- All psychological testing

Inpatient admissions to acute care facilities for
- Medical/surgical
- Adjunctive dental
- Organ and stem cell transplants
- Substance abuse
- Mental health
- Acute care facilities include
  - Hospitals
  - Skilled nursing facilities
  - Subacute/rehabilitation
  - Long term acute care
  - Residential treatment facilities
- Residential treatment center admissions for children and adolescents
- Observation for more than 48 hours
- Transplant, solid organ, bone marrow, peripheral stem cell—consult, evaluation and transplant procedures